Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPREHENSIVE PAIN MANAGEMENT
5734 SPOHN DRIVE SUITE A
CORPUS CHRISTI TX 78414

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-07-6657-01

MFDR Date Received
JUNE 7, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physician saw the patient for an office visit for his compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. Carrier paid for procedure code 99213 but denied codes J7799, 62368 and 95991 for this date of service."

Amount in Dispute: $1,668.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines and whether the documentation provided supports the level of services. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 12, 2006	Pain Pump Refill - HCPCS Code J7799 KD	$1500.00	$0.00
	CPT Code 62368	$67.03	$0.00
	CPT Code 95991	$101.17	$0.00
TOTAL		$1,668.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 15, 2007, applicable to disputes filed on or after January 15, 2007 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Explanation of benefits dated December 20, 2006

- 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- 172-Payment is adjusted when performed/billed by a provider of this specialty.
- W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- 42-Charges exceed our fee schedule or maximum allowable amount.
- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.

Explanation of benefits dated May 11, 2007

- 18-Duplicate claim/service.
- 172-Payment is adjusted when performed/billed by a provider of this specialty.

Issues

1. Is the requestor entitled to reimbursement for HCPCS code J7799-KD?
2. Does the documentation support billing of CPT code 62368? Is the requestor entitled to reimbursement?
3. Does the documentation support billing of CPT code 95991? Is the requestor entitled to reimbursement?

Findings

1. Neither party to this dispute submitted a copy of an explanation of benefits for HCPCS code J7799-KD. The respondent did not dispute in the position summary that the service is not eligible for dispute resolution; therefore, the service will be reviewed per applicable Division rules and guidelines.

   28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   HCPCS code J7799-KD is defined as "NOC drugs, other than inhalation drugs, administered through DME."

   28 Texas Administrative Code §134.202 (c)(2) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L:

   (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

   (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or

   (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6 of this subsection."

   The Division finds that HCPCS code J7799-KD does not have a fee listed in DMEPOS fee schedule nor a Medicaid rate.

   28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

Neither party to the dispute submitted documentation to support that the carrier had assigned a relative value for the HCPCS code J7799-KD in accordance with 28 Texas Administrative Code §134.202(c)(6).

28 Texas Administrative Code §134.1 that "requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor seeks full reimbursement of billed charges.
- The requestor did not submit documentation to support that reimbursement of $1,500.00 is fair and reasonable.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

2. The respondent denied reimbursement for CPT code 62368 based upon reason code "16"

   CPT code 62368 is defined as "Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming." The requestor's documentation does not support billing; therefore, reimbursement is not recommended.

3. The respondent denied reimbursement for CPT code 95991 based upon reason code "16"

   CPT code 95991 is defined as" Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional."

   The requestor did not submit a report to support billing of this service; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/13/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.